STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175376	A. BUILDING _____ B. WING _____	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APOSTOLIC CHRISTIAN HOME	511 PARAMOUNT ST SABETHA, KS 66534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey.	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This Requirement is not met as evidenced by: The facility had a census of 86 residents. The sample included 14 residents. Based upon observation, record review and interviews the facility failed to ensure Broda chairs were the least restrictive chair for 2 (#87, #1) of 2 sampled residents. Findings included: -Resident #87's significant change Minimum Data Set (MDS) dated 8/25/14 identified the resident scored 04 (severely impaired cognition) on the Brief Interview for Mental Status (BIMS) , had behaviors, required extensive staff assistance with bed mobility, transfers, the activity of walking in the room/corridor did not occur, was totally dependent upon staff for locomotion on/off the unit, dressing, toilet use and personal hygiene. The resident was not steady and was only able to stabilize with human assistance when moving from seated to standing, moving on/off the toilet, surface to surface transfers and the activity of walking did not occur, and had functional limitations on both sides of his/her lower extremities and utilized a wheelchair. The MDS identified the resident had not fallen since admission or the prior assessment.	F 221		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 221	Continued From page 1	F 221		

The resident's ADL Care Area Assessment (CAA) dated 8/26/14 included the resident required extensive staff assistance with ADLs, was unable to do by himself/herself and was not aware of his/her needs and safety anymore.

The resident's Fall CAA dated 5/8/14 documented to see the resident's fall assessment and balance test.

The resident's Fall CAA dated 8/26/14 included the resident was at risk for falls, was non weight bearing on his/her left leg, did not remember that, and needed many reminders and interventions.

The resident's Fall Assessment dated 5/1/14 identified the resident scored 22 (a score of 10 or higher represented the resident was at risk for falls).

The resident's care plan last reviewed/revised on 11/7/14 included the resident had impaired physical mobility related to a history of falls and a hip fracture. Staff monitored the resident's mobility, the resident utilized a self-locking wheelchair and staff frequently reminded the resident to ask and wait for help.

A fall occurrence note dated 10/22/14 timed 5:21 A.M. documented at 4:00 A.M. included if the resident was awake in the middle of the night, especially during rounds, staff transferred the resident to the wheelchair so he/she could move himself/herself about.

A nurse's note dated 11/14/14 and timed 8:15 P.M. documented the resident fell at 4:00 P.M. The resident partially stood up, leaned to his/her

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F 221	Continued From page 2	F 221		

left and fell. The resident stated he/she did not need to use the bathroom, stated he/she was not going anywhere, he/she just wanted to see if he/she could stand.

Review of the resident's clinical record lacked evidence the facility thoroughly assessed the resident to determine that the Broda chair was the least restrictive chair for the resident.

On 11/17/14 at 7:10 A.M. the resident sat in a Broda chair in a reclined position. The resident's feet did not reach the ground and the resident was moving his/her feet in an attempt to propel the chair. Further observation revealed the resident had red colored abrasions on his/her left forehead and left cheek bone.

On 11/17/14 at 10:45 A.M. direct care staff T stated the resident was at risk for falls and prior to the resident's fall a couple of days ago the resident sat in a self-locking wheelchair which the resident self propelled. Direct care staff T stated the Broda chair prevented the resident from rising independently.

On 11/17/14 at 2:31 P.M. licensed nurse L stated the resident was at risk for falls. The resident fell out of his/her wheelchair on 11/14/14. Licensed nurse staff L stated prior to Friday's fall the resident utilized a self-locking wheelchair and after the fall the facility placed the resident in the Broda chair. Licensed nurse L stated the Broda chair was not a restraint; however the Broda chair slowed the resident's response time in getting out of the chair without staff assistance.

On 11/17/14 at administrative nursing staff D stated the resident was at risk for falls.

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F 221	Continued From page 3 Administrative nursing staff D stated prior to the resident's fall on 11/14/14 the resident utilized a self-locking wheelchair which he/she self propelled. Administrative nursing staff D stated after the resident's fall on 11/17/14 the facility placed the resident in the Broda chair. Administrative nursing staff D stated the Broda chair was not considered a restraint for the resident but the Broda chair slowed the resident's response time from getting out of the chair without staff assistance. Administrative nursing staff D stated the resident was not able to propel the Broda chair. The facility failed to ensure this resident was free from physical restraints when staff failed to thoroughly assess the resident to ensure the Broda chair was the least restrictive device for the resident. - Resident #1's quarterly Minimum Data Set (MDS) dated 10/20/14 included the resident scored 15 (cognitively intact) on the Brief Interview for Mental Status, had no behaviors,and required extensive staff assistance with bed mobility, transfers, dressing and personal hygiene. The MDS included the resident was totally dependent upon staff with toilet use, locomotion on/off the unit and did not walk on/off unit. The resident was not steady and was only able to stabilize with human assistance when moving from seated to standing position, moving on/off the toilet and surface to surface transfers. The resident had no functional limitation in range of motion, utilized a walker and wheelchair, was frequently incontinent of urine and was on a toileting program. The MDS identified the resident had 2 or more no injury falls since the prior assessment.	F 221		

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The resident's Activity of Daily Living (ADL) Care Area Assessment (CAA) dated 5/22/14 included the resident had a history of falls.

The resident's Fall CAA dated 5/22/14 included the resident had difficulty maintaining a standing position and had an impaired balance.

The resident's care plan last revised/reviewed on 11/4/14 addressed the resident had an alteration in thought processes due to an intellectual disability, had a self care deficit related to a muscular skeletal impairment, required staff assistance of 1 with transfers via the sit to stand lift. The resident had difficulty with decision making.When staff reminded the resident of his/her safety issues the resident displayed anger and resisted assistance when needed. The resident had a potential for falls due to a decrease in muscle strength, and had a history of falls. Staff frequently reminded the resident to stay in the Broda chair. An entry dated 8/14/14 included staff frequently reminded the resident to get close to things in his/her room and to not attempt to reach out and fall out of his/her Broda chair, staff kept the resident's closet door shut when not in use. An entry dated 9/21/14 included the resident utilized a Broda chair with foot pedals and staff ensured the Broda chair was lowered from the upright position after meals.

A fall and occurrence note dated 5/16/14 and timed 1:06 A.M. documented at 10:15 P.M. staff observed the resident on the floor in his/her room. Interventions included staff consulted with physical therapy about a Broda chair, staff reminded the resident constantly to ask for staff assistance and to not bend down and reach for things on the floor. The resident had several falls, had recently slid from the wheelchair and

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refused help from staff. The resident now utilized a Broda chair with dycem placed in the chair to help keep the resident from sliding.

A certified physical therapy assistant note dated 5/19/14 and timed 4:10 P.M. documented the resident was in a chair like a Broda chair, the resident did not complain about the chair and he/she did not ask the resident.

Review of the resident's clinical record lacked evidence to support physical or occupational therapy assessed the resident prior to the facility placing the resident in the Broda type chair.

On 11/13/14 at 4:50 P.M. the resident sat in the Broda chair and staff propelled the resident up the hallway. Observation revealed the Broda chair had foot pedals in place and the Broda chair was in a reclined position.

On 11/17/14 at 7:20 A.M. the resident sat in the Broda chair in his/her room. Observation revealed no foot pedals in place, the resident sat forward in the chair, and attempted to propel the chair with much difficulty. The resident stated he/she utilized the Broda chair because he/she had fallen and could not walk. The resident stated prior to using the Broda chair he/she had a wheelchair which he/she could move. The resident stated he/she did not like the Broda chair because he/she could not maneuver the Broda chair.

On 11/17/14 at 11:44 A.M. the resident sat in the Broda chair and staff propelled the resident. Observation revealed no foot pedals in place and the Broda chair in a reclined position.

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F 221	Continued From page 6 On 11/1/7/14 at 10:45 A.M. direct care staff T stated the resident was at risk for falls and utilized a Broda chair. Direct care staff T stated the resident could not independently rise from the Broda chair when the chair was in a reclined position. On 11/17/14 at 2:25 P.M. licensed staff L stated the resident was at risk for falls and utilized a Broda chair to minimize falls. Licensed nurse L stated the Broda chair was not considered a restraint for the resident but slowed the resident's time in rising from the chair. On 11/17/14 at 3:43 P.M. administrative nursing staff D stated the resident was at risk for falls, and utilized a Broda type chair for positioning to prevent falls. The facility failed to ensure this resident was free from physical restraints when staff failed to thoroughly assess the resident to ensure the Broda chair was the least restrictive device for the resident.	F 221		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a	F 225		

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F 225	Continued From page 7 court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This Requirement is not met as evidenced by: The facility identified a census of 86 residents. The sample included 17 residents. Based on observation, record review, and interview facility staff members failed to immediately report abuse of 1 (#65) resident to the administrator and the facility failed to report an allegation of abuse for 1 resident (#34) to the state agency. Findings included:	F 225		

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F 225	Continued From page 8 - The annual Minimum Data Set 3.0 (MDS) dated 9/9/14 for resident #65 revealed a Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive impairment. The NN dated 9/5/14 at 11:41 A.M. revealed on 9/4/14 at approximately 5:00 P.M. a staff member reported an instance of abuse towards the resident that occurred on 9/3/14 at approximately 9:00 P.M. Staff reported that a certified nurse assistant (CNA) slapped the resident and was verbally abusive towards him/her. The charge nurse was advised to monitor and assess the resident for any symptoms or changes related to the event. The resident had no noted marks, bruises, or pain and was cooperative and relaxed at the time of assessment. The investigation provided by the facility on 11/13/14 at approximately 11:15 A.M. revealed a timeline of the incident. The report showed the incident occurred on 9/3/14 at approximately 9:00 P.M.. Direct care staff R reported the event to the director of nursing via telephone on 9/4/14 at approximately 4:40 P.M. regarding direct care staff P abusing the resident physically and verbally. The direct care staff who witnessed the incident failed to immediately report the abuse to their supervisors. Observation on 11/12/14 at 1:40 P.M. revealed the resident sat in a wheelchair in the dining room while picking at his/her clothing. Interview on 11/17/14 at 9:09 A.M. via phone with licensed nursing staff I revealed he/she was the charge nurse on the night of the abuse but was not witness to and was not notified of the event by	F 225		

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F 225	Continued From page 9 the direct care staff. Interview on 11/17/14 at 9:18 A.M. with direct care staff P revealed the resident was being resistive to cares and hitting, spitting at the staff. Staff P admitted to slapping the resident. He/she stated the CNAs should have left the resident alone. Interview on 11/17/14 at 4:09 P.M. with direct care staff Q revealed he/she was also present and witnessed the abuse but did not report it to anyone prior to leaving the facility that night. Interview on 11/17/14 at 4:24 P.M. with administrative staff D revealed the direct care staff that witnessed the abuse failed to notify anyone of the abuse until the following day. Staff D stated he/she re-educated the staff members of the expectation for immediate reporting of any type of abuse. The undated policy provided by the facility regarding abuse, neglect, and exploitation revealed the facility held mandatory orientation to all staff in regards to abuse. The administrator and director of nursing were to be notified immediately. Facility staff failed to immediately report abuse to the administrator and director of nursing. - Resident #34's significant change Minimum Data Set (MDS) dated 10/22/14 included the	F 225		

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resident scored 03 (severely cognitively impaired) on the Brief Interview for Mental Status had 2 or more injury except major falls and 2 or more major injury falls since the prior assessment.

The resident's care plan last revised on 11/4/14 included the resident was at risk for injury related to a decline in his/her cognitive ability, the resident fell or nearly fell in the past 180 days.

A fall and occurrence note dated 9/16/14 and timed 11:58 A.M. documented that at 10:30 P.M. the resident was on the floor. The resident ambulated without his/her safety device and urine was on the floor from the resident's bed to his/her bathroom.

An X-ray report dated 9/17/14 included the resident had pain after a fall. The impression of the x-ray included the resident had a minimally displaced fracture in the region of the head of the left fibula (the outer and narrower of the two bones in the human lower leg between the knee and the ankle).
A fall and occurrence note dated 9/19/14 and timed 6:44 A.M. included at 4:30 A.M. the resident was on the floor in his/her room and had a right scalp laceration. The note included staff entered the resident's room and told the resident to get up and go to the bathroom. The staff then went next door while the resident got up. Staff heard the resident hit the floor, entered the resident's room and the resident laid at the foot of his/her bed with blood coming from his/her scalp. Staff assisted the resident into the bed and instructed the resident to hold a "rag" over his/her forehead while he/she located the nurse. Prior to the beginning of the shift, the staff was informed the resident fell two days ago and the resident should be assisted to the bathroom and the staff

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F 225	Continued From page 11 stated he/she forgot. On 11/13/14 at 2:30 P.M. administrative nursing staff E stated he/she was informed of the staff not assisting the resident with ambulation the morning of the 9/19/14. Administrative nursing staff D who was present stated he/she did not notify the state agency of the allegation of neglect. The facility's undated Resident Abuse, Neglect, Exploitation and Mistreatment Policy and Procedure defined neglect as the failure or omission by one's self, caretaker or another person to provide goods or services which were necessary to ensure safety and well-being and to avoid physical or mental harm or illness...once a complaint was registered either verbally or in writing, the facility notified the Abuse Hotline immediately after the incident. The facility failed to report an allegation of abuse regarding an unwitnessed fall which resulted in a fracture to the state agency.	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This Requirement is not met as evidenced by: The facility had a census of 86 residents. Based upon record review and interview the facility failed to check former employer references for 4 of the 5 employee personnel files reviewed. Findings included:	F 226		

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F 226	Continued From page 12 - Review of direct care staff Q's personnel file revealed the employee's hire date was 8/29/14. Review of the employee's application revealed direct care staff Q listed previous employers. Further review of the employee's personnel file lacked evidence to support the facility performed a reference check with the employee's former employers. On 11/13/14 at 10:00 A.M. administrative nursing staff D confirmed the employee's personnel file lacked evidence the facility checked the former employer for reference(s). The facility's undated Resident Abuse, Neglect, Exploitation and Mistreatment Policy and Procedure included ...all potential employees would be screened before employment. References would be called and possible interviews with current employees to assess if the facility staff knew the applicant. The facility failed to conduct reference checks with the employee's former employer. - Review of direct care staff MM's personnel file revealed the employee's hire date was 11/2/14. Review of the employee's application revealed direct care staff MM listed previous employers. Further review of the employee's personnel file lacked evidence to support the facility performed a reference check with the employee's former employers. On 11/13/14 at 10:00 A.M. administrative nursing staff D confirmed the employee's personnel file lacked evidence the facility checked the former employer reference(s).	F 226		

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F 226	Continued From page 13 The facility's undated Resident Abuse, Neglect, Exploitation and Mistreatment Policy and Procedure included ...all potential employees would be screened before employment. References would be called and possible interviews with current employees to assess if the facility staff knew the applicant. The facility failed to conduct reference checks with the employee's former employer. - Review of licensed nurse N's personnel file revealed the employee's hire date was 10/13/14. Review of the employee's application revealed licensed nurse N listed previous employers. Further review of the employee's personnel file lacked evidence to support the facility performed a reference check with the employee's former employers. On 11/13/14 at 10:00 A.M. administrative nursing staff D confirmed the employee's personnel file lacked evidence the facility checked the former employer reference(s). The facility's undated Resident Abuse, Neglect, Exploitation and Mistreatment Policy and Procedure included ...all potential employees would be screened before employment. References would be called and possible interviews with current employees to assess if the facility staff knew the applicant. The facility failed to conduct reference checks with the employee's former employer. - Review of direct care staff R's personnel file revealed the employee's hire date was 7/12/14. Review of the employee's application revealed	F 226		

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F 226	Continued From page 14 direct care staff R listed previous employers. Further review of the employee's personnel file lacked evidence to support the facility performed a reference check with the employee's former employers. On 11/13/14 at 10:00 A.M. administrative nursing staff D confirmed the employee's personnel file lacked evidence the facility checked the former employer reference(s). The facility's undated Resident Abuse, Neglect, Exploitation and Mistreatment Policy and Procedure included ...all potential employees would be screened before employment. References would be called and possible interviews with current employees to assess if the facility staff knew the applicant. The facility failed to conduct reference checks with the employee's former employer.	F 226		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This Requirement is not met as evidenced by: The facility identified a census of 86 residents. Based on observation, interview and record review the facility failed to maintain a safe, sanitary environment for in the common areas of the facility, and in 7 resident rooms. Findings included: - On 11/10/14 at approximately 9:45 A.M. during the initial tour of the facility, observation of the	F 253		

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F 253	Continued From page 15 dining room and main hall revealed multiple cracks in the floor tile and the floor was not level. The facility had ripped, missing and stained wallpaper in multiple areas that included the main hallway, assisted dining room, southwest hallway, northwest hallway, and northeast hallway. The northwest hall had 3 water stained spots on the ceiling. The southwest hall contained rubber baseboard trim that peeled away from the wall. The main hallway revealed multiple scrapes and broken areas in the sheet rock. On 11/10/14 at 1:18 P.M. and during environmental tour on 11/13/14 at approximately 10:15 A.M. revealed a bathroom in a resident's room contained cracked flooring tile by the toilet and multiple scratches on the bottom of the bathroom door. On 11/10/14 at 1:48 P.M. and during environmental tour on 11/13/14 at approximately 10:15 A.M. revealed 2 resident rooms contained multiple scratches in the wall by the resident's beds. The resident's bathroom contained toothbrushes in a dirty cup, a urine collection cylinder uncovered rested on the back of the toilet, with a thick yellow substance in the cylinder, and a crack in the bathroom flooring that extended the length of the bathroom. On 11/10/14 at 2:29 P.M. and during environmental tour on 11/13/14 at approximately 10:15 A.M. revealed a resident's bathroom contained an uncovered bed pan that rested on the back of the toilet. On 11/10/14 at 3:04 P.M. and during environmental tour on 11/13/14 at approximately 10:15 A.M. revealed a resident room with wallpaper peeling off the wall beside the bed.	F 253		

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F 253	Continued From page 16 On 11/12/14 at 10:02 A.M. and during environmental tour on 11/13/14 at approximately 10:15 A.M. revealed a resident room with broken sheet rock that was visible behind the recliner chair. On 11/12/14 at 10:33 A.M. and during environmental tour on 11/13/14 at approximately 10:15 A.M. revealed a room with scuffs on wall near the entrance of the room. On 11/12/14 at 10:34 A.M. and during environmental tour on 11/13/14 at approximately 10:15 A.M. revealed a resident bathroom contained a rust ring around the base of the toilet. On 11/13/14 at approximately 10:15 A.M. maintenance staff X stated he/she was aware of the general wear and tear of the building. He/she stated staff communicated environmental concerns through the computer system or staff would notify him/her. On 11/13/14 at 11:00 A.M. direct care staff O stated if there was a concern with the environment he/she communicated this to the charge nurse. On 11/13/14 at 11:04 A.M. licensed nursing staff H stated environmental concerns were filled out on the computer and sent to the maintenance department. The facility did not provide a policy for general maintenance of the facility. The facility failed to maintain a safe, sanitary environment for the residents of the facility.	F 253		
F 279	483.20(d), 483.20(k)(1) DEVELOP	F 279		

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F 279 SS=E	Continued From page 17 COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This Requirement is not met as evidenced by: The facility reported a census of 86 residents, with 17 residents in the sample. Based on observation, interview and record review, the facility failed to develop an individualized comprehensive plan of care for 4 of 17 residents sampled. (#65, # 40, # 87, #70) Findings included: - Resident # 40's Quarterly Minimum Data Set dated 9/2/14 recorded the resident with a Brief Interview for Mental Status Score of 3 which indicated the resident with severe cognitive impairment. The resident required extensive assistance with bed mobility, transfers, dressing,	F 279		

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and personal hygiene. The MDS recorded the resident received an antipsychotic (medications used to manage psychosis (any major mental disorder characterized by a gross impairment in reality testing)) and antidepressant (medication used to treat depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness)) medication for 7 days during the 7 day look back of the MDS assessment.

The Psychotropic Medication Use Care Area Assessment (CAA) dated 3/20/14 recorded the resident was on an antidepressant and needed the medication for his/her quality of life, to assist him/her with losses, and a history of depression. A care plan would be developed and staff would continue with the current care plan.

The Black Box Warning (BBW) care plan record noted the resident took Celexa (an antidepressant) and staff were to monitor the medication appropriately and observe closely for clinical worsening, suicidal, or unusual changes in behaviors. The resident took Seroquel, an antipsychotic, drug was not indicated for use in elderly patients with Dementia (progressive mental disorder characterized by failing memory, confusion) related psychosis because of an increased risk of death from Cardiovascular disease (pertaining to the heart and blood vessels) or infection. There were no adverse side effects from the medication. The resident took Zyprexa (an antipsychotic), the drug could increase the risk of cardiovascular disease or infection related to death in elderly patients with dementia.

The care plan lacked specific behaviors that staff

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were to monitor for.

The Medication Administration Record (MAR) recorded the resident took Seroquel 25 milligrams (mg) daily in the evening for dementia with associated hallucinations, delusional disorder, and depression.
The nurses note dated 9/1/14 at 9:15 A.M. recorded the resident had delusions, crying, tearfulness and believed his/her mother or oldest sister had died. At 5:07 P.M. the resident was combative, swung hands/fists, threatened others, was uncooperative, verbally abusive, and disruptive.

The nurses note dated 10/11/14 at 11:21 P.M. recorded the resident was agitated, crying/tearful and wanted to find his/her daughters. He/she did not understand why he/she was in the facility and wanted to call the police. He/she looked around the facility for someone to help him/her.
The nurses note dated 11/8/14 at 4:30 P.M. recorded the resident had hallucinations, when he/she was in bed he/she told staff there were little black bugs on the ceiling. Staff turned the lights on for the resident and put his/her glasses on, he/she still saw the little black bugs on the ceiling.

Observation on 11/12/14 at 1:39 P.M. revealed the resident sat in his/her recliner in his/her room.

Interview on 11/17/14 at 9:36 A.M. direct care staff S stated resident #40 did not have behaviors that he/she knew of. He/she stated he/she had access to the care plans.

Interview on 11/17/14 at 10:01 A.M. licensed nursing staff J stated resident # 40 had behaviors in the past. He/she stated staff intervene with the

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residents behaviors by calling his/her loved one. There should have been a care plan for antipsychotic medications and staff needed to be able to look it up.

Interview on 11/17/14 at 11:02 A.M. licensed nursing staff L stated staff care planned for resident's on antipsychotic medications, which included interventios for behaviors.

Interview on 11/17/14 at 2:10 PM licensed nursing staff K stated he/she would expect there to be an antipsychotic care plan if a resident received antipsychotic medications. He/she knew what behaviors to look for in resident by looking at the Medication Administration Record (MAR) and he/she charted on the behaviors.

Interview on 11/17/14 at 2:28 P.M. administrative nursing staff E stated if a resident was on an antipsychotic medication, the name of the medication would not be listed in the care plan. He/she tried to stay broad in his/her care plans and did not write anything specific for medications. He/she stated his/her care plan was pretty generic for resident #40's medications and behavior.

The facility failed to develop an individualized comprehensive plan of care for this severely cognitively impaired resident taking antipsychotic medications and exhibiting behaviors.

- Resident #70's Quarterly MDS dated 10/20/14 recorded the resident had a BIMS score of 8 which indicated the resident had moderately impaired cognition. The resident was independent with bed mobility, walking in his/her room and corridor, and locomotion on and off of the unit. The resident required supervision for

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transfers, dressing, eating, toilet use, and personal hygiene.

The Activities of Daily Living (ADLs) CAA dated 8/5/14 recorded the resident needed supervision to assure appropriate dress and dignity. The resident needed supervision and cueing with ADLs due to his/her cognition problems. He/she was able to complete his/her ADLs with cueing and supervision. A care plan would be developed and staff would continue to use the current plan. The ADL care plan dated 11/4/14 recorded the resident needed supervision related to his/her Alzheimer's (progressive mental deterioration characterized by confusion and memory failure). Staff were to offer simple instructions to encourage the resident to participate, he/she was independent with all ADLs but needed supervision.
Observation on 11/12/14 at 1:44 P.M. revealed the resident sat in his/her room at the desk.
Interview on 11/17/14 at 9:36 A.M. direct care staff S stated resident #70 needed cueing with his/her activities of daily living and oral cares.
Interview on 11/17/14 at 9:55 A.M. direct care staff U stated resident #70 needed cueing for activities of daily living (ADLs) and he/she put toothpaste on his/her toothbrush and laid his/her comb out for the resident. He/she stated she checked the toothbrush to make sure the resident used it.
Interview on 11/17/14 at approximately 3:30 P.M. direct care staff V stated resident #70 did his/her own ADL care. The resident was independent and staff V did not set up oral care for the resident. He/she had never reminded the resident to brush his/her teeth or hair.

Interview on 11/17/14 at 11:02 A.M. licensed nursing staff L stated resident #70 had upper and

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lower partials in. The aides made sure his/her teeth were brushed and he/she always left his/her partials in. He/she did his/her own oral care but the CNA's prompted him/her. His/her oral care was not careplanned. The CNA's knew what to do for the resident based off of aides flowsheet. Licensed nursing staff L opened the CNA flow sheet which revealed oral care information was not provided.

Interview on 11/17/14 at 2:28 P.M. administrative nursing staff E stated care plans for oral care was not written unless the resident needed assistance. If a resident required a set-up, it would be care planned.

Interview on 11/17/14 at 2:39 P.M. administrative nursing staff D stated resident oral cares were available on the flow sheets the CNA's used. The facilities policy provided staff do oral care every morning and evening and it should be on the care plan. If there was a deviation from the standard care, such as assistance, cueing, or set up, the policy was staff do whatever is appropriate for that resident. The facility based their oral cares on their policies. The care plan would show how much assistance the resident needed for ADL's.

The facility's undated Oral Care policy recorded all residents would receive oral care to promote a healthy mouth. All residents would receive twice a day oral care unless otherwise specified. It would be careplanned if the resident needed set up only, was independent or total assist was required with the task based on individual need.

The undated Care Plan policy provided by the

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facility recorded a care plan would be developed for each resident. The care plan would include measurable objectives and timetables to meet all residents needs identified in the comprehensive assessment. The care plan described services furnished to attain or maintain the residents highest practicable physical, mental and psychosocial well-being.

The facility failed develop an individualized comprehensive plan of care for this cognitively moderately impaired resident who required set up for his/her oral care.

- The annual Minimum Data Set (MDS) dated 9/9/14 for resident #65 revealed a Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive impairment. He/she displayed fluctuating signs and symptoms of delirium (sudden severe confusion, disorientation and restlessness) including disorganized thinking and altered level of consciousness, which was not an acute change. The resident also displayed physical and verbal behavioral symptoms directed towards others which interfered with his/her care and put others at significant risk for physical injury. These behaviors were noted to be the same as previous assessments. He/she required extensive assistance from 1 staff member for transfer, walking in his/her room, dressing, toilet use, and personal hygiene. During the 7 day look back period the resident received 7 doses of an antipsychotic (medication used for the treatment of psychosis; any major mental disorder characterized by a gross impairment in reality testing) and 7 doses of an antidepressant (medication used for the treatment of depression; abnormal emotional state characterized by

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exaggerated feelings of sadness, worthlessness and emptiness).

The 9/10/14 Care Area Assessment (CAA) regarding behaviors revealed he/she required redirection and reassurance from staff due to behaviors. At times he/she needed time to calm down and staff respected his/her boundaries. Staff was to develop a care plan regarding the resident's behaviors.

The care plan with a revision date of 9/5/14 failed to address the resident's behaviors and appropriate staff approaches for those behaviors.

Observation on 11/12/14 at 1:40 P.M. revealed the resident sat in a wheelchair in the dining room while picking at his/her clothing.

Interview on 11/17/14 at 3:58 P.M. with administrative nursing staff E revealed he/she acknowledged the staff should have developed the resident's care plan to address his/her behaviors. Staff should ensure the resident was safe and leave him/her alone if he/she was being aggressive.

Interview on 11/17/14 at 4:24 P.M. with administrative nursing staff D revealed he/she expected staff to address on the care plan the resident's behaviors and ways for staff to work with him/her when he/she displayed those behaviors.

The undated policy provided by the facility regarding care plans revealed the care described services furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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F 279	Continued From page 25 The facility failed to develop a comprehensive and individualized care plan addressing behaviors for this cognitively impaired resident. - Resident #87's significant change Minimum Data Set dated 6/14/14 identified the resident scored 05 (severely impaired cognition) on the Brief Interview for Mental Status (BIMS), had physical behavioral symptoms directed toward others 1 to 3 days of the 7 day assessment period, verbal behaviors directed toward others 4 to 6 days but less than daily during the 7 day assessment period and had other behavioral symptoms not directed toward others 4 to 6 days but less than daily during the 7 day assessment period. The MDS coded the resident's behavior placed the resident at risk for physical illness or injury, significantly interfered with the resident's care, significantly interfered with the resident's participation in activities or social interactions, significantly intruded on the privacy or activity of others, significantly disrupted the care or living environment, and the resident rejected care 4 to 6 days but less than daily during the 7 day assessment period. The MDS coded the resident had wandering tendencies that occurred 1 to 3 days during the 7 day assessment period and the resident's behaviors worsened. The MDS did not identify the resident received psychotropic medications. The resident's significant change MDS dated 8/25/14 identified the resident scored 04 (severely impaired cognition) on the BIMS, had delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), physical behavioral symptoms directed toward others 4 to 6 days during the 7 day assessment period, verbal behaviors toward others 4 to 6 days during the 7	F 279		

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day assessment period and did not have other behavioral symptoms, and the resident's behaviors remained the same. The MDS identified the resident required extensive staff assistance with bed mobility, transfers, the activity of walking in the room/corridor did not occur, was totally dependent upon staff for locomotion on/off the unit, dressing, toilet use and personal hygiene. The MDS did not identify the resident utilized psychotropic medications.

The resident's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 8/26/14 documented the resident's cognition varied a lot due to the resident's stress and pain level.

The resident's 8/26/14 Behavior CAA included to see the resident's nurse's notes and plan of care for interventions and the facility developed a care plan to address the resident's behaviors.

The resident's care plan last reviewed/revised on 11/7/14 included the resident was cognitively impaired, staff explained changes, explained procedures, spoke slowly and clearly to the resident and allowed the resident ample time to respond. Staff approached the resident in calm, gentle manner and reoriented the resident as needed and staff reported the resident's agitation to the nurse. The resident had a decline in cognitive status, the resident had a potential for chronic pain and displayed pain behaviors and staff administered pain medications as physician ordered.

The resident's care plan did not include interventions as to how staff should approach the resident and what interventions staff should take when the resident refused treatment/care and was verbally and physically abusive toward staff

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 27 and upset other residents. Review of the resident's nurse's notes from 6/1/14 to 11/14/14 revealed the resident was physical abusive to staff and intruded on other residents On 11/17/14 at 12:00 P.M. the resident sat in a recliner. Observation revealed 2 staff members placed a sit and stand lift in front of the resident and asked the resident to place his/her hands on the lift so the staff could transfer the resident from the recliner. Further observation revealed the resident swung at staff and stated something that was not understandable. Staff continued to attempt to get the resident to place his/her hands on the handle of the sit and stand lift and the resident again swung at the staff. Staff attempted again to get the resident to place his/her hands on the lift, the resident swung and almost hit one of the staff in the face. At that time, the staff removed the sit and stand lift and did not re-approach the resident. On 11/17/14 at 10:45 A.M. direct care staff T stated at times the resident was combative. Direct care staff T stated during the month of October the facility held an in-service regarding dealing with behaviors related to residents with Alzheimer's (progressive mental deterioration characterized by confusion and memory failure)/dementia (progressive mental disorder characterized by failing memory, confusion). Direct care staff T stated the facility had not educated staff on how to deal specifically with this resident's behaviors. On 11/17/14 at 1:38 P.M. social service staff HH stated some of the resident's behaviors were due to pain and the anesthesia (a treatment with	F 279		

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F 279	Continued From page 28 certain medicines that puts one into a deep sleep so one does not feel pain during surgery) the resident received when he/she had surgery. Social service staff HH stated staff managed the resident's behavior via a pain management program, staff approached the resident in a calm and gentle manner and placed the resident on a toileting program which were all included in the resident's care plan. Social service staff stated nursing staff developed behavior interventions and if the nursing staff required more assistance with resident's behaviors, social services and nursing staff discussed the issue. On 11/17/14 at 2:31 P.M. licensed nurse L stated at times the resident was combative and often times had behaviors. Licensed nurse L stated staff explained things to the resident and approached him in a calm manner according to the care plan. The facility failed to develop an individualized comprehensive care plan for this resident with behaviors.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This Requirement is not met as evidenced by: The facility had a census of 86 residents. The sample included 17 residents. Based upon record review, observation and interview the	F 309		

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F 309	Continued From page 29 facility failed to thoroughly assess and develop interventions for 1 (#87) resident with behaviors, failed to assess to ensure 1 (#16) resident's dialysis (procedure where impurities or wastes were removed from the blood) shunt was patent and failed to perform neurological checks for 1 (#44) resident after falls. Findings included: - Resident #87's significant change Minimum Data Set (MDS) dated 6/14/14 identified the resident scored 05 (severely impaired cognition) on the Brief Interview for Mental Status (BIMS), had physical behavioral symptoms directed toward others 1 to 3 days of the 7 day assessment period, verbal behaviors directed toward others 4 to 6 days but less than daily during the 7 day assessment period and had other behavioral symptoms not directed toward others 4 to 6 days but less than daily during the 7 day assessment period. The MDS coded the resident's behavior placed the resident at risk for physical illness or injury, significantly interfered with the resident's care, significantly interfered with the resident's participation in activities or social interactions, significantly intruded on the privacy or activity of others, significantly disrupted the care or living environment, and the resident rejected care 4 to 6 days but less than daily during the 7 day assessment period. The MDS coded the resident had wandering tendencies that occurred 1 to 3 days during the 7 day assessment period and the resident's behaviors worsened. The MDS identified the resident required extensive assistance with bed mobility, transfers, walking in the corridor and dressing, did not walk in the room, was totally dependent upon staff with locomotion on/off the unit, toilet use and personal hygiene. The MDS identified the	F 309		

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resident had frequent pain, and received scheduled and as needed (PRN) pain medications The MDS did not identify the resident received psychotropic medications.

The resident's significant change assessment dated 8/25/14 identified the resident scored 04 (severely impaired cognition) on the BIMS, had delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), physical behavioral symptoms directed toward others 4 to 6 days during the 7 day assessment period, verbal behaviors toward others 4 to 6 days during the 7 day assessment period and did not have other behavioral symptoms, and the resident's behaviors remained the same. The MDS identified the resident required extensive staff assistance with bed mobility, transfers, the activity of walking in the room/corridor did not occur, was totally dependent upon staff for locomotion on/off the unit, dressing, toilet use and personal hygiene. The MDS did not identify the resident utilized psychotropic medications.

The resident's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 8/26/14 documented the resident had experienced cognitive loss,and the resident's cognition varied a lot due to the resident's stress and pain level.

The resident's 8/26/14 Behavior CAA included reference to the nurse's notes and plan of care for interventions.

The resident's care plan last revised on 11/7/14 included the resident was cognitively impaired,

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staff explained changes, explained procedures, spoke slowly and clearly to the resident and allowed the resident ample time to respond. Staff approached the resident in calm, gentle manner and reoriented the resident as needed and staff reported the resident's agitation to the nurse. The resident had a decline in cognitive status, the resident had a potential for chronic pain and displayed pain behaviors and staff would administer pain medications as the physician ordered.

The resident's November 2014 Medication Administration Record (MAR) included the resident received 500 milligrams (mg) of Tylenol twice a day for pain since 6/7/14, Zoloft 50 mg daily since 8/4/14 for depression, Ativan 0.5 mg every 8 hours as needed for agitation since 4/30/14, Tylenol 650 mg every 4 hours as needed for fever and headache since 5/1/14 and Oxycodone 5 mg every 4 hours as needed for moderate to severe pain.

Further review of the resident's November 2014 MAR included staff administered 0.5 mg of Ativan to the resident on 11/4/14 and 11/6/14. Staff administered 5 mg of Oxycodone for pain to the resident on 11/2/14, on 11/6/14 and on 11/8/14.

A nurse's note (NN) dated 6/29/14 (time unknown) documented a direct care staff attempted to help the resident into bed and the resident hit the staff member in the face.

A NN dated 7/2/14 and timed 1:28 A.M. included at approximately 7:30 P.M. people went through the door by the bird cage to the apartments. The resident wheeled himself/herself over to the door after it shut and wanted out. The resident yelled and kicked the door, stated he/she wanted to go

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home to the country, staff tried to redirect the resident without success. The resident hit the charge nurse with his/her fist in the arm, kicked at another resident, punched a direct care staff in the eye and demanded staff contact the sheriff. The staff contacted a family member to come to the facility to calm the resident down.

A NN dated 7/13/14 and timed 3:26 A.M. documented starting at 11:00 P.M. the resident pulled his/her incontinent product off in front of other residents. The resident kept climbing out of the recliner and tried to transfer himself/herself. The resident went into others rooms and woke residents up. Staff tried to redirect the resident, and the resident became combative. At 3:30 A.M. he/she went into another resident's room and tried to transfer himself/herself to the toilet. Staff tried to explain to the resident it was not his/her room and the resident started to kick, and scratch. It took 3 staff members to calm the resident down and to get him/her out of the other resident's room.

A NN dated 8/14/14 and timed 3:19 A.M. included on the evening of 8/13/14 the resident was agitated, hit staff several times as they attempted to take the resident to the bathroom. The resident kicked another resident's walker and resisted toileting. Staff did not toilet the resident due to combativeness.

A NN dated 8/17/14 and timed 9:28 A.M. documented the resident hit several staff as they attempted to put the resident in his/her recliner from his/her wheelchair, the resident was combative and hit at staff.

A NN dated 9/22/14 and timed 2:38 P.M. documented the resident removed the sole of

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his/her shoe and used it to hit staff. The resident was very restless. Staff redirected, toileted, massaged/touched, reassured, reoriented, changed the resident's position, offered the resident food and the resident's behavior was unchanged.

A NN dated 10/11/14 and timed 10:55 A.M. included the resident entered other resident's rooms looking for machinery and became angry with redirection.

A NN dated 10/16/14 and timed 11:09 A.M. documented the resident was agitated, combative, disruptive, hit, screamed, yelled, shouted and was physically abusive. The resident's behavior was not easily altered. Interventions included staff redirected, offered toileting, massaged/touched, reassured and offered food and the resident's behavior was unchanged.

A NN dated 10/20/14 and timed 9:18 P.M. included the resident went into other resident's rooms looking for his/her family member, kicked at doors that were shut and yelled in the hallways which upset the residents. Staff administered 0.5 milligrams (mg) of Ativan (an anti-anxiety medication) for agitation.

A NN dated 11/2/14 and timed 1:41 A.M. documented the resident wandered throughout the facility, wandered into other resident's rooms and the resident's behavior was not easily altered.

A NN dated 11/4/14 and timed 3:52 A.M. documented the resident woke other residents, and slammed doors which agitated the other residents. The resident hit and kicked 4 times (the note did not specify who or what the resident

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hit or kicked). The note included from approximately 12:00 A.M. until 2:30 A.M. the resident yelled and shouted, slammed doors and staff redirected, toileted, massaged/touched, reassured, reoriented and gave the resident food. The resident's behavior was unchanged and worsened at times.

A NN dated 11/5/14 and timed 12:16 P.M. documented while staff pushed the resident to lunch, the resident raised his/her fist backwards and hit the staff member in the nose and the resident had no signs of agitation prior to that.

A NN dated 11/8/14 and timed 10:21 P.M. documented the resident sat on the foot rest of the recliner, the recliner was about to flip over, the resident would not allow staff to assist him/her or allow staff to place the sit to stand lift on him/her. Staff was finally able to get sit to stand on him/her and staff placed the resident in his/her wheelchair. The resident was agitated, combative and staff redirected, toileted, massaged, reassured and provided food to the resident.

Review of the resident's clinical record lacked evidence the facility thoroughly assessed the causal factors of the resident's behavior failed to provide medically related social services to the resident regarding his/her behaviors, and failed to contact a mental health specialist regarding the resident's behavior.

On 11/17/14 at 12:00 P.M. the resident sat in a recliner. Observation revealed 2 staff members placed a sit and stand lift in front of the resident and asked the resident to place his/her hands on the lift so the staff could transfer the resident from the recliner. Further observation revealed the

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resident swung at staff and stated something that was not understandable. Staff continued to attempt to get the resident to place his/her hands on the handle of the sit and stand lift and the resident again swung at staff. Staff attempted again to get the resident to place his/her hands on the lift, the resident swung and almost hit one staff member in the face. At that time, the staff removed the sit and stand lift and did not re-approach the resident.

On 11/17/14 at 10:45 A.M. direct care staff T stated at times the resident was combative. Direct care staff T stated during the month of October the facility held an in-service regarding dealing with behaviors related to residents with Alzheimer's (progressive mental deterioration characterized by confusion and memory failure)/dementia (progressive mental disorder characterized by failing memory, confusion). Direct care staff T stated the facility had not educated staff on how to deal specifically with this resident's behaviors.

On 11/17/14 at 1:38 P.M. social service staff HH stated some of the resident's behaviors were due to pain and the anesthesia (a treatment with certain medicines that puts one into a deep sleep so one does not feel pain during surgery) the resident received when he/she had surgery. Social service staff HH stated staff managed the resident's behavior via a pain management program, staff approached the resident in a calm and gentle manner and placed the resident on a toileting program. Social service staff stated nursing staff developed behavior interventions and if the nursing staff required more assistance with the resident's behaviors, social services and nursing staff discussed the issue. Social service staff HH stated he/she had not provided medically

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related social service assistance nor had the facility discussed the resident's behavior with a mental health specialist.

On 11/17/14 at 2:31 P.M. licensed nurse L stated at times the resident was combative and often times had behaviors. Licensed nurse L stated staff explained things to the resident and approached him/her in a calm manner.

The facility failed to thoroughly assess the casual factors of the resident's behavior, failed to provide medically related social services and or contact a mental health specialist for this resident with behaviors that significantly affected the resident and other residents that resided in the facility.

- Resident #16's diagnoses included the resident had a diagnosis of end stage renal disease ESRD (a terminal disease because of irreversible damage to the kidneys).

The resident's quarterly Minimum Data Set dated 9/30/14 identified the resident scored 15 on the Brief Interview for Mental Status, had no behaviors, required extensive staff assistance with bed mobility, toilet use, transfers, walking in the corridor, the activity of walking in room did not occur, he/she was totally dependent with locomotion on/off the unit and dressing. The MDS identified the resident received dialysis.

The resident's Nutritional Care Area Assessment (CAA) dated 4/15/14 included the resident had End Stage Renal Disease the resident's weight fluctuated due to the resident received dialysis.

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F 309	Continued From page 37 The resident's care plan last revised dated on 10/29/14 included the resident received dialysis, had a port site in his/her left upper arm and had a diagnosis of end stage renal disease. An entry dated 10/29/14 per dialysis directive, staff made sure the port dressing was dry and intact when the resident returned from dialysis, and the next day the nurse removed the band-aid from the resident's left upper arm port. Staff checked the resident's blood pressure and pulse immediately when the resident returned from dialysis and documented the results in the resident's Treatment Administration Record (TAR). The resident's care plan did not include the licensed nurse auscultated (listened) and palpated (felt) the resident's dialysis access site every shift for a thrill and bruit (distinct feeling over the fistula and the sound of the blood whooshing through the fistula). Review of the resident's November Medication Administration Record (MAR) and TAR did not include the licensed nurse checked the access site for a thrill and bruit. On 11/13/14 at 7:20 A.M. the resident sat in his/her wheelchair in his/her room. The resident stated he/she went to dialysis on Monday, Wednesday and Friday. Observation revealed the resident's dialysis port site was in his/her upper left arm. On 11/17/14 at 2:22 P.M. licensed nurse I stated the dialysis center determined what the facility assessed on the resident's dialysis site. Licensed nurse I stated the licensed nurse did not ensure the port was patent by checking for a thrill and bruit.	F 309		

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F 309	Continued From page 38 On 11/17/14 at 3:43 P.M. administrative nursing staff D stated staff checked the resident's vitals when the resident returned from dialysis. Administrative nursing staff D stated dialysis nurses instructed the facility whether to check the site for a thrill and bruit and the dialysis center had not instructed the facility to assess the patency of the site. The facility's Dialysis Policy and Procedure reviewed on 8/27/13 included when the resident returned from dialysis, licensed nursing staff would be informed and would immediately assess the site and take all vitals signs. The facility failed to ensure the resident's dialysis port was patent. - The quarterly Minimum Data Set (MDS) dated 9/10/14 for resident #44 revealed a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. He/she displayed signs and symptoms of delirium (sudden severe confusion, disorientation and restlessness) as evidence by fluctuating inattention. The resident required extensive assistance from 1 staff member for bed mobility, transfer, dressing, toilet use, and personal hygiene. He/she was not steady and required assistance from staff to stabilize when moving from seated to standing, walking, turning around while walking, moving on/off the toilet, and surface-to-surface transfers. The resident had 1 non-injury fall since the previous assessment. The 3/27/14 Care Area Assessment (CAA) regarding falls revealed the resident was a fall risk and frequently got in and out of bed on	F 309		

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his/her own. The resident did accept staff assistance for toileting. The resident used a locking wheelchair which helped reduce his/her falling.

The care plan with a revision date of 11/5/14 revealed the resident was at risk for falls related to a decline in cognitive status.

The fall investigations in the electronic medical record (eMR) revealed the resident had unwitnessed falls on 9/12/13, 4/28/14, and 8/6/14. The investigation for the 9/12/13 unwitnessed fall revealed the nurse documented the resident to be confused. The investigation for the 4/28/14 unwitnessed fall revealed the resident's mental status was disoriented. The investigation for the 8/6/14 unwitnessed fall showed the nurse noted the resident to be confused, as normal but to have increased lethargy. Review of the documentation lacked evidence that the nursing staff completed neurological checks.

Interview on 11/17/14 at 10:41 A.M. with direct care staff W revealed the resident was a fall risk and was intermittently confused.

Interview on 11/17/14 at 2:41 P.M. with licensed nursing staff J revealed the resident was a fall risk and forgetful at times. Staff J stated if this resident had an unwitnessed fall then he/she would initiate neurological checks due to memory impairment.

Interview on 11/17/14 at 4:43 P.M. with

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F 309	Continued From page 40 administrative nursing staff D revealed the facility's policy did not instruct staff to perform neurological checks for unwitnessed falls. The undated policy provided by the facility regarding falls stated neurological checks were performed when a resident had a "blow to the head." The undated policy provided by the facility regarding neurological checks revealed staff were to initiate neurological checks when a resident sustained a head injury or reported a head injury but failed to address what to do for an unwitnessed fall of a cognitively impaired resident. The facility failed to perform neurological checks after unwitnessed falls for this cognitively impaired resident.	F 309		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This Requirement is not met as evidenced by: The facility had a census of 86 residents. The sample included 17 residents. Based upon record review, observation and interview the	F 314		

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facility failed to provide adequate treatment and services to prevent pressure ulcers for 1 (#87) of 1 sampled resident.

Findings included:

- Resident #87's Physician Order Sheet (POS) dated 9/19/14 included the resident had a diagnoses that included : Diabetes Mellitus Type 2 (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), hypertension (elevated blood pressure), hyperlipidemia (condition of elevated blood lipid levels), inguinal herniaprotrusion of an organ through an abnormal opening in the muscle wall of the cavity that surrounds it), atrial fibrillation (rapid, irregular heart beat) and cervical spinal stenosis (narrrowing of the spinal column in the neck). The POS also included staff applied and changed a polymen dressing to the resident's Stage 2 pressure ulcers on the back of the resident's left lower leg and heel.

The resident's admission Minimum Data Set (MDS) dated 5/6/14 identified the resident scored 00 (severely impaired cognition) on the Brief Interview for Mental Status (BIMS) and had behaviors. The MDS identified the resident required extensive staff assistance with bed mobility, transfers, walking in the corridor, dressing, eating, was totally dependent upon staff for personal hygiene, toilet use, and locomotion on/off the unit. The MDS included the resident was at risk for the development of pressure ulcers and did not have unhealed pressure ulcers.

The resident's significant change assessment dated 8/25/14 identified the resident scored 04 (severely impaired cognition) on the BIMS,

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had behaviors, required extensive staff assistance with bed mobility, transfers, the activity of walking in the room/corridor did not occur, was totally dependent upon staff for locomotion on/off the unit, dressing, toilet use and personal hygiene. The MDS identified the resident was at the risk for the development of pressure ulcers, had (1) Stage 2 pressure ulcer present upon admission/reentry and the date of the oldest pressure ulcer was 7/25/14. The MDS identified the resident had an open lesion on his/her foot, utilized a pressure relieving device for his/her bed and chair, and was not on a turning/repositioning program.

The resident's Activity of Daily Living (ADL) Care Area Assessment (CAA) dated 8/26/14 included the resident required extensive staff assistance with ADLs, was unable to do by himself/herself and was not aware of his/her needs and safety.

The resident's pressure ulcer CAA dated 8/26/14 documented the resident had a pressure ulcer on the outer aspect of his/her left foot. The physician debrided the area and the resident was at risk for more breakdown.

The resident's care plan last reviewed/revised on 11/7/14 included the resident required the assistance of 1 staff with ADLs. An entry dated 9/16/14 included the resident had an impairment in skin integrity, the resident had a pressure ulcer on his/her left heel, stasis ulcers present times 3 on his/her left calf. Staff assessed the resident's condition daily and documented any changes and staff measured the areas twice a week. Staff minimized pressure on the resident's bony prominences, the resident slept in a recliner so an air mattress was not appropriate. An entry dated

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9/21/14 included staff applied a Roho cushion (pressure relieving device) under both of the resident's lower legs when the resident sat in the recliner and ensured the resident's heels dangled over the edge of the ROHO cushion. The care plan did not address the resident was on a turning/repositioning program.

The resident's laboratory report dated 7/23/14 included the resident's Albumin level was low at 3.2 grams/deciliter (normal refrence range 3.4 to 5.0 grams/deciliter).

The resident's Skin/Foot condition reports dated 7/22/24 included the resident had a bunion like area on the outer aspect of his/her left foot, the area was reddened and painful and the resident wore no shoes that day.

The resident's Skin/Foot condition report dated 7/25/14 included the resident had a Stage 2 pressure ulcer on the posterior aspect of his/her left foot near the great toe joint. The depth was unknown due to a scab formation, the bunion area was approximately the size of a quarter with an open area in the center that measured approximately 0.2 centimeters (cm) and staff applied a bunion pad over the area. The resident wore TED hose, recently had severe edema and the edema combined with the TED hose caused pressure and the resident's family was looking into purchasing the resident diabetic shoes.

The resident's Skin/Foot condition report dated 8/5/14 included the resident had a Stage 2 pressure ulcer on his/her left outer foot that

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measured 0.2 cm in diameter, the resident wore a slipper sock only on that foot.

The resident's Skin/Foot condition report dated 8/27/14 documented the resident had a Stage 2 pressure ulcer on the outer aspect of his/her left foot. The record lacked documentation regarding the area after that date.

Observation on 11/13/14 at 10:25 A.M. revealed the resident did not have unhealed pressure ulcer on the outer aspect of his/her left foot.

The resident's Skin/Foot condition report dated 9/16/14 documented the resident had a Stage 2 fluid filled blister pressure ulcer on his/her left heel. A Stage 2 pressure ulcer on his/her left leg directly toward the bottom of his/her left calf that measured 1.3 cm by 1.3 cm with an unknown depth due to a dark colored scab. The report also included the resident had a Stage 2 on his/her left lower calf that measured 1.7 cm by 1.3 cm with a depth of 0.1 cm. The report included the resident had a Stage 2 pressure ulcer on his/her left leg right above the heel area that measured 2.5 cm by 1.7 cm with a depth of 0.2 cm and a dark thin scab was present in the wound bed. The facility received a physician's order to apply Polymen and to obtain a wound consult.

The resident's skin condition report dated 9/23/14 documented the Stage 2 pressure ulcer directly above the resident's left heel measured 2.8 cm by 1 cm and the pressure ulcer was brown. The Stage 2 pressure ulcer on the bottom half of the

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the resident's left calf measured 0.6 cm by 0.7 cm with an unknown depth due to a brown colored scab. The Stage 2 pressure ulcer on the resident's left lower calf measured 0.7 cm in diameter and had a depth of less than 0.1 cm. The Stage 2 pressure ulcer on the resident's left leg directly above the heel area measured 1 cm by 2 cm with a depth of 0.1 cm, the area contained 60 percent (5) pink tissue and 40% tan tissue. Documentation included staff placed a Roho cushion (pressure relieving device) under the resident's legs when the resident sat in the recliner.

According to the skin condition report the Stage 2 pressure ulcer on the bottom half of the resident's left calf healed on 9/30/14. The Stage 2 pressure ulcer on the resident's lower calf measured 0.2 cm in diameter and the Stage 2 pressure ulcer on the resident's left heel measured 3 cm by 1.7, the area was no longer fluid filled, the skin was brown in color and intact. The Stage 2 pressure ulcer on the resident's left leg directly above the heel measured 2.5 cm by 1.4 cm and had a yellowed colored center. Staff applied Santyl (a debriding ointment) with a Telfa dressing and wrapped the area.

According to the resident's skin condition report the pressure ulcer on the resident's left lower calf resolved on 10/17/14. The Stage 2 pressure ulcer on the resident's left heel measured 2.5 cm by 1.0 cm and was tan in color. The The Stage 2 pressure ulcer directly above the resident's left heel measured had a depth of 0.1 cm and measured 1.5 cm by 0.9 cm.

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According to the resident's skin condition report the Stage 2 pressure ulcer on the resident's left heel resolved on 10/24/14. The Stage 2 pressure ulcer on the resident's left leg directly above the heel measured 1.5 cm by 0.4 cm with serous drainage.

The resident's skin condition report dated 11/11/14 documented the Stage 2 pressure ulcer directly above the resident's left heel measured 1.2 cm by 0.3 cm was tan in color and had an unknown depth due to a scab formation.

A Physical Therapist note dated 9/23/14 included staff moisturized the resident's skin twice a week on bath days, but not between the resident's toes. Staff applied a short stretch compression wrap to the resident's foot and leg on in the A.M. and off in the P.M. and rewrapped during the day as needed. Staff performed a daily dressing change with Santyl and Telfa and applied a gauze top dressing. Staff continued to offload the resident's heel and ankle with the Roho cushion.

A PT note dated 10/7/14 documented the wounds were healing well. The resident continued to have fibrin covering the wound bed of the largest wound and all other wounds are closed. Nursing staff continued Santyl, and compression for 1 week, then discontinue the Santyl and use a foam dressing and changed it twice a week after baths and to continue with the short stretch compression wrap until healed.

The resident's clinical record lacked evidence to support the facility thoroughly

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assessed the resident's position when the resident sat in the recliner to ensure pressure was not applied to the resident's bony prominences when the resident sat in the recliner. The resident's clinical record lacked evidence to support staff offloaded the resident's heels/legs prior to the development of the pressure ulcers.

On 11/13/14 at 7:10 A.M. staff propelled the resident toward the dining room. Observation revealed the resident's wheelchair had a pressure relieving device.

On 11/13/14 at 7:25 A.M. the resident ate his/her breakfast meal which consisted of a bowl of cream of wheat, biscuit and gravy, bacon, apple juice, coffee and water. The resident had consumed 50 percent (%) of the cream of wheat, 75% of the biscuit and gravy and all of the bacon. Observaiton revealed the resident ate independently.

On 11/13/14 at 7:35 A.M. the resident had consumed all of the food and liquids.

On 11/13/14 at 12:20 P.M. the resident sat in his/her wheelchair at a dining room table and ate the lunch meal which consisted of chicken pie, broccoli salad, slice of pear pie, water and coffee.

On 11/13/14 at 12:30 P.M. the resident had consumed 25% of the chicken pie and brocoli salad and was eating the slice of pear pie. The resident stated the food hurt his/her cavities and therfore he/she was not going to eat it.

On 11/13/14 at 12:35 P.M. the resident conumed all of the pie and 25% of the food as noted. There was no evidence to support staff offered

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the resident an alternative to the meal.
On 11/14/14 at 10:25 A.M. licensed nurse M performed the dressing on the pressure ulcer directly above the resident's heel on the resident's left foot. Observation revealed the pressure ulcer measured approximately 1.0 cm by 0.25 cm and licensed nurse M described the pressure ulcer as tan in color and a dark colored scab in the center of the wound bed. Observation confirmed the description of the pressure ulcer as described by licensed nurse M. Licensed nurse M stated the resident originally had 3 pressure ulcers on his/her left foot/leg due to the resident's legs/feet rubbed against the foot rest of the recliner. Licensed nurse M stated after the development of the areas staff placed the Roho cushion under the resident's legs/feet when he/she sat in the recliner. Licensed nurse M stated the resident had slept in the recliner since a week after the resident's admission to the facility. Licensed nurse M stated the facility did not offload the resident's feet/legs when the resident sat in the recliner until after the development of the pressure ulcers.

On 11/13/14 tat 1:00 P.M. and 2:00 P.M. the resident sat in the wheelchair.

On 11/17/14 at 7:10 A.M. the resident sat in a Broda chair.

On 11/17/14 at 10:30 A.M. the resident sat in a recliner, the foot rest of the recliner was elevated and a Roho cushion was under the resident's legs/feet.

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F 314	Continued From page 49 On 11/17/14 at 10:45 A.M. direct care staff T stated the resident slept in the recliner. Direct care T stated staff was not on a turning/repositioning program because staff toileted the resident at least every 2 hours. On 11/17/14 at 2:31 P.M. licensed nurse L stated the resident had slept in the recliner since a week or so after admission. Licensed nurse L stated prior to the development of the pressure ulcer on the resident's left heel/calf staff did not offload the resident's legs/feet. Licensed nurse L stated the facility as well as the physical therapist identified the areas as pressure ulcers. On 11/17/14 administrative nursing staff stated the resident developed the open areas while in the facility. Administrative nursing staff D stated he/she was not sure if the areas were considered pressure or stasis ulcers. Administrative nursing staff D stated staff did not offload the resident's legs/feet until after the development of the open areas. On 11/19/14 at 9:13 A.M. physical therapy staff consultant II stated the areas on the resident's left calf and heel would be labeled as pressure ulcers although the areas were not on a bony prominence. Physical therapy consultant II stated not all pressure ulcers are on bony promnences. Physicial therapy staff II stated the pressure ulcers were most likely caused from the resident's legs resting against the foot rest of the recliner. The facility failed to offload this resident's legs/feet when he/she sat in the recliner and also failed to deveop a turning/repositiong program for	F 314		

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F 314	Continued From page 50 this resident assessed to be at risk for the development of pressure ulcers. According to the resident's skin condition reports this resident developed (3) facility acquired pressure ulcers and the pressure ulcer above the resident's left heel was an unstageable pressure ulcer.	F 314		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: The facility had a census of 86 residents. The sample included 17 residents. Based upon record review, observation, and interview, the facility failed to provide fall interventions for one resident #44, timely interventions and reassessment of root cause analysis for 2 residents with falls, (#34, #1), failed to maintain safe hot water temperatures, and failed to ensure resident rooms were free of accident hazzards. Findings included: - The quarterly Minimum Data Set 3.0 (MDS) dated 9/10/14 for resident #44 revealed a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. He/she displayed signs and symptoms of delirium (sudden severe confusion, disorientation and	F 323		

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restlessness) as evidence by fluctuating inattention. The resident required extensive assistance from 1 staff member for bed mobility, transfer, dressing, toilet use, and personal hygiene. He/she was not steady and required assistance from staff to stabilize when moving from seated to standing, walking, turning around while walking, moving on/off the toilet, and surface-to-surface transfers. The resident had 1 non-injury fall since the previous assessment.

The 3/27/14 Care Area Assessment (CAA) regarding falls revealed the resident was a fall risk and frequently got in and out of bed on his/her own. The resident did accept staff assistance for toileting. The resident used a locking wheelchair which helped reduce his/her falls.

The 3/27/14 CAA regarding Activities of Daily Living (ADLs) revealed the resident's short term memory was poor and he/she required cues and reminders from staff. He/she required assistance from 1 staff member for dressing and toilet use.

The care plan with a revision date of 11/5/14 revealed the resident was at risk for falls related to a decline in cognitive status. Staff encouraged the resident to ask staff for assistance and not stand independently. Staff toileted the resident before and after meals, at bedtime, on first rounds, and as needed. On 9/13/13 a toilet riser was placed over the resident's toilet to provide security for toileting. As of 8/6/14 the nurse aides performed 30 minute checks on the resident. On 10/21/14 staff kept the resident's bed in a low position.

The fall investigation in the electronic medical record (eMR) dated 9/12/13 at 11:31 P.M.

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revealed staff observed the resident on the floor on the bathroom on 9/12/13 at 11:15 P.M. He/she was toileting at the time. The possible cause was listed as "without staff assist sat down on floor." The resident was not able to articulate how the incident occurred but it appeared the resident leaned too far to the left when providing self peri-care and lost his/her balance, at which time the stool riser came off the toilet. No injuries were noted upon assessment. Staff placed a new toilet riser with arms and rubber tipped feet on the resident's toilet. The new intervention listed was to remind the resident often to call for help.

The fall investigation in the eMR dated 4/29/14 at 2:55 A.M. revealed on 4/28/14 at 10:45 P.M. staff observed the resident on the floor of his/her room. The resident reported to staff that he/she missed the wheelchair when getting him/herself off the toilet. Staff reminded the resident to use the call light for assistance and encouraged him/her to keep the door to his/her room partially open.

The fall investigation in the eMR dated 8/6/14 at 11:13 P.M. revealed on 8/6/14 at 10:10 P.M. staff observed the resident on the floor in his/her room. The resident reported to staff he/she was attempting to go to the bathroom independently and fell. Staff implemented a new intervention for 30 minute checks.

The fall investigation in the eMR dated 10/21/14 at 12:08 A.M. revealed on 10/20/14 at 10:35 P.M. staff observed the resident on the floor. The resident reported to staff he/she was transferring him/herself to the wheelchair to go to the bathroom but missed the chair and landed on the floor. Staff implemented a new intervention of a low bed and reminded the resident to call for

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F 323	Continued From page 53 assistance with transfers. Observation on 11/17/14 at 11:48 A.M. revealed direct care staff W assisted the resident to transfer from a wheel chair to his/her bed using a gait belt. The resident required verbal cueing from staff for transfer. Interview on 11/17/14 at 10:41 A.M. with direct care staff W revealed the resident was a fall risk. He/she reported staff reminded the resident to use his/her call light and kept the bed in the low position due to him/her being a fall risk. Staff W stated the resident was confused at times. Interview on 11/17/14 at 2:41 P.M. with licensed nursing staff J revealed the resident was a fall risk and forgetful at times. Staff J acknowledged reminding this resident to use his/her call light may not be an appropriate intervention for this resident due to cognitive impairment. Staff J also acknowledged toileting a resident at a specific time that he/she had multiple falls would be appropriate. Interview on 11/17/14 at 4:43 P.M. with administrative nursing staff D revealed administrative nursing staff reviewed post fall interventions for appropriateness for that resident. Staff D stated reminding this resident to use his/her call light would not be an effective intervention. Staff D reported the facility attempted to do education regarding toileting schedules and fall prevention. The undated policy provided by the facility regarding falls failed to address the use of resident appropriate interventions to reduce the risk for future falls.	F 323		

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F 323	Continued From page 54 The facility failed to develop appropriate and effective interventions to prevent future falls for this cognitively impaired resident with multiple falls. - Resident #34 's Physician Order Sheet (POS) dated 9/19/14 included the resident had diagnoses that included Dementia (progressive mental disorder characterized by failing memory, confusion) with behavior disturbances, hyertension (elevated blood pressure), osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), and psychosis any (major mental disorder characterized by a gross impairment in reality testing). The resident's significant change Minimum Data Set (MDS) dated 10/22/14 included the resident scored 03 (severely cognitively impaired) on the Brief Interview for Mental Status, required extensive staff assistance with bed mobility, transfers, locomotion off unit, dressing, toilet use and personal hygiene and walking in the corridor, the activity of walking in room did not occur and required limited staff assistance with locomotion on the unit. The MDS identified the resident was not steady and was only able to stabilize with human assistance when moved from seated to standing position, walking, turning around and facing the opposite direction while walking and surface to surface transfers, had a functional impairment on one side of his/her upper and lower extremity, utilized a walker and a wheelchair. The MDS coded the resident was frequently incontinent of urine, was on a toileting program, and had 2 or more injury except major falls and 2 or more major injury falls since the prior assessment.	F 323		

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F 323	Continued From page 55 The resident's ADL Care Area Assessment (CAA)dated 10/27/14 included the resident had recent falls and fractures and was unable to safely ambulate independently, required lots of reminders to ask and wait for help and staff would not leave the resident alone in his/her room. The CAA documented the resident's fibula (lower leg) and right wrist were fractured and the resident's right wrist was in a cast. The resident's Fall CAA dated 10/27/14 included staff toileted the resident every hour during the night and frequently reminded the resident the staff was there to assist him/her and the resident often forgot that he/she required staff assistance. The resident's Fall Assessment dated 5/2/13 identified the resident scored 13. The resident's Fall Assessment dated 6/2/14 identified the resident scored 21. According to the legend a score of 10 and higher represented the resident was at high risk for falls. The resident's care plan last reviewed/revised on 11/4/14 included the resident was at a potential for injury related to a decline in his/her cognitive, the resident fell or nearly fell in the past 180 days, staff encouraged the resident to ask for assistance, instructed him/her on safety, and required frequent reminders. Staff reported all unsafe conditions and situations, ensured the resident's call light was within reach, toileted the resident before and after meals, and before activities and every hour from midnight to 6:00 A.M. every day. The resident required staff assistance of 1 with ADLs including transfers related to Alzheimer's (progressive mental deterioration characterized by confusion and memory failure) and staff never left the resident	F 323		

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unattended in his/her room. Staff performed 30 minute checks, had a low bed, a self locking wheelchair, a pad alarm on his/her bed that was connected to the call system.

A fall and occurrence note dated 10/8/13 and timed 11:21 P.M. documented that at 5:20 P.M. the resident was on floor. Interventions included staff spoke with resident about not walking so fast as the resident had the habit of going at full throttle and kept his/her feet too close together and staff encouraged the resident to use his/her walker. Investigation interviewed staff, Resident stated tripped self when began to walk with walker, staff thought was steady on her feet after giving her the walker, almost had herself up by the time staff nurse got down the hall. There was no evidence to support the facility reassessed the resident for the causal factor of the fall.

A fall and occurrence note dated 9/16/14 and timed 11:58 A.M. documented that at 10:30 P.M. the resident was on the floor. The resident ambulated without his/her safety device and urine was on the floor from the resident's bed to his/her bathroom. Interventions included staff toileted the resident before and after meals and before and after activities. There was no evidence to support the facility reassessed the resident for the causal factor of the fall.

An X-ray report dated 9/17/14 included the resident had pain after a fall. The impression of the x-ray included the resident had a minimally displaced fracture in the region of the head of the left fibula.

A fall and occurrence note dated 9/19/14 and timed 6:44 A.M. included at 4:30 A.M. the resident was on the floor in his/her room and had

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a right scalp laceration. The note included staff entered the resident's room and told the resident to get up and go to the bathroom. The staff then went next door while the resident got up. Staff heard the resident hit the floor, entered the resident's room and the resident laid at the foot of his/her bed with blood coming from his/her scalp. Staff assisted the resident into the bed and instructed the resident to hold a "rag" over his/her forehead while he/she located the nurse. Prior to the beginning of the shift, the staff was informed the resident fell two days ago and the resident should be assisted to the bathroom and the staff stated he/she forgot. Intervention included staff assisted the resident with all ambulation. There was no evidence to support the facility reassessed the resident for the causal factor of the fall.

A fall and occurrence note dated 9/23/14 and timed 11:41 P.M. included at 9:05 P.M. the resident was on the floor in his/her room. The investigation note included staff toileted the resident after supper, the resident then spent the evening in activities playing bingo. When the activity was over, the resident went back to his/her room, apparently stood and fell from his/her wheelchair hitting his/her right arm against the sink. The resident complained of right wrist pain and the resident's right wrist immediately swelled. Interventions included staff performed 30 minute checks on the resident. There was no evidence to support the facility reassessed the resident for the causal factor of the fall.

A hospital's discharge instruction form dated 9/23/14 and timed 10:40 P.M. included the resident had a fracture radius and ulna.

A fall occurrence note dated 9/27/14 and timed

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2:08 P.M. documented at 12:55 P.M. staff observed the resident on the floor in his/her room. The note included the resident attempted to ambulate independently to the bathroom. Interventions included a self locking wheelchair was already in place and staff initiated a low bed. There was no evidence to support the facility reassessed the resident for the causal factor of the fall.

A fall occurrence note dated 10/21/14 and timed 11:07 P.M. included at 7:45 P.M. staff observed the resident on the floor and the resident's upper back scratched. The note included the resident sat on the side of his/her bed, slid down to floor, the bed was in the lowest position, the resident had taken off his/her shoes and in stocking feet. Intervention included the facility placed a mat bedside the resident's bed. There was no evidence to support the facility reassessed the resident for the causal factor of the fall.

A fall occurrence note dated 10/23/14 and timed 3:22 A.M. documented at 3:00 A.M. the resident was on the floor in his/her room and the left side of the resident's back had an abrasion. The resident's bed alarm activated but staff could not get there fast enough. Intervention included staff performed 30 minute checks. There was no evidence to support the facility reassessed the resident for the causal factor of the fall.

On 11/12/14 at 3:00 P.M. the resident laid in bed. Observation revealed the resident's bed in a low position, and a bed alarm in place.

On 11/13/14 at 8:00 A.M. the resident sat in a wheelchair at the dining room table.

On 11/17/14 at 12:30 P.M. direct care staff T

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transferred the resident from the wheelchair to the toilet via a gait belt.

On 11/17/14 at 11:30 A.M. direct care staff T stated the resident was at risk for falls. Staff toileted the resident before and after meals, the resident had a low bed and no fall mat. Direct care staff T stated the fall mat presented more of a hazard the facility discontinued the use of the mat. Direct care staff T stated the resident required staff assistance with transfers and did not ambulate independently.

On 11/17/14 at 2:36 P.M. administrative nursing staff D stated the resident was at risk for falls, fell and sustained 2 fractures during the month of September 2014. Administrative nursing staff stated the resident utilized a low bed, self locking wheelchair and a bed pad alarm.
The facility failed to place timely and effective interventions and to reassess the resident to determine casual factors of the falls for this severely cognitively impaired resident with a history of falls who sustained a right wrist fracture and a left fibia fracture.

- Resident #87's admission Minimum Data Set (MDS) dated 5/6/14 identified the resident scored 00 (severely impaired cognition) on the Brief Interview for Mental Status (BIMS) and had behaviors. The MDS identified the resident required extensive staff assistance with bed mobility, transfers, walking in the corridor, dressing, eating, was totally dependent upon staff for personal hygiene, toilet use, and locomotion on/off the unit. The resident was not steady and was only able to stabilize with staff assistance when moving from seating to standing position, walking, moving on/off the toilet, surface to surface transfers, had a functional limitation on

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both sides of his/her upper extremity and on one side of his/her lower extremity and utilized a walker and a wheelchair. The resident fell within the last month, the last 2 to 6 months prior to admission, had a fracture related to a fall in the 6 months prior to admission and had not fallen since admission.

The resident's significant change assessment dated 8/25/14 identified the resident scored 04 (severely impaired cognition) on the BIMS, had behaviors, required extensive staff assistance with bed mobility, transfers, the activity of walking in the room/corridor did not occur, was totally dependent upon staff for locomotion on/off the unit, dressing, toilet use and personal hygiene. The resident was not steady and was only able to stabilize with human assistance when moving from seated to standing, moving on/off the toilet, surface to surface transfers and the activity of walking did not occur, and had functional limitations on both sides of his/her lower extremities and utilized a wheelchair. The MDS identified the resident had not fallen since admission or the prior assessment.

The resident's Activity of Daily Living (ADL) Care Area Assessment (CAA) dated 5/8/14 included the resident required staff assistance with all ADLs, wanted to do things on his/her own but was unable and still thought he/she could at times. The resident was at risk for falls, needed constant monitoring, was independent prior to his/her hip fracture (prior to admission) and was able to do his/her own cares.

The resident's ADL CAA dated 8/26/14 included the resident required extensive staff assistance with ADLs, was unable to do by himself/herself

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and was not aware of his/her needs and safety. anymore.

The resident's Fall CAA dated 5/8/14 documented to see the resident's fall assessment and balance test.

The resident's Fall CAA dated 8/26/14 included the resident was at risk for falls, was non weight bearing on his/her left leg, did not remember that, and needed many reminders and interventions.

The resident's Fall Assessment dated 5/1/14 identified the resident scored 22 (a score of 10 or higher represented the resident was at risk for falls).

The resident's care plan last reviewed/revised on 11/7/14 included the resident had a self care deficit and required staff assistance of 1 with ADLs, staff toileted the resident before and after meals, at bedtime and as needed per his/her request, and staff ensured the resident's call light was within reach. The care plan addressed the resident had impaired physical mobility related to a history of falls and a hip fracture. Staff monitored the resident's mobility, the resident utilized a self-locking wheelchair and staff frequently reminded the resident to ask and wait for help. Staff monitored the resident closely and anticipated the resident's fall times. The facility had interventions in place to prevent the resident from standing alone and falling. The resident did not sleep in a bed, preferred to sleep in a recliner in the sitting area by the nurse's station. Due to his/her sleeping preference a pad alarm and monitor was not able to be used and with the position of the recliner staff was able to constantly observe the resident. Staff did not leave thee resident unattended when toileting, unless the sit

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F 323	Continued From page 62 to stand lift was in a locked position. A fall occurrence note dated 6/4/14 and timed 8:49 A.M. included at 6:15 A.M. the resident was on the floor. The note included the resident was in the recliner, attempted to transfer himself/herself and fell. The resident stated he/she needed to go to the bathroom and attempted to transfer self. The note included the facility reviewed the resident's toileting program in relationship to the fall. Staff toileted the resident before and after meals, before bed and as requested by the resident. Intervention included the facility would ensure the resident wore properly fitting shoes versus slipper socks. There was no evidence to support the facility reassessed the resident to determine the causal factors of the fall. A hospital's History and Physical dated 6/4/14 included the resident fell at the nursing facility and fractured his/her left hip. The note included the resident had a past surgical history that included an Open Reduction and Internal Fixation (ORIF-a type of surgery used to repair broken bones) on his/her right hip on 4/26/14 (prior to the resident's admission to the facility). An Operative report dated 6/4/14 included the date of the operation was 6/4/14, Preoperative and Postoperative Diagnosis included a left hip fracture and the procedure included an intramedullary nail fixation left intertrochanteric hip fracture (procedure used to fix hip fracture). A fall occurrence note dated 7/12/14 and timed 10:37 A.M. documented at 8:10 A.M. the resident fell in another resident's bathroom. The resident was incontinent of urine and bowel. Intervention included included staff would toilet the resident	F 323		

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immediately after breakfast. There was no evidence to support the facility reassessed the resident to determine the causal factors of the fall.

An X-Ray report dated 7/26/14 and timed 10:10 A.M. documented at 7:45 A.M. the resident attempted to transfer by himself/herself and fell. Interventions included staff applied moisturizer each morning during care and continued to toilet the resident before and after meals.

An X-Ray report dated 8/8/14 included the resident fell 2 weeks ago, was having severe pain, could not bear weight, had a recent hip pinning on 6/4/14 and no definite acute abnormality observed..

A Physician's progress note dated 10/2/14 included the resident's left hip fracture was not healing quickly.

A fall occurrence note dated 10/22/14 timed 5:21 A.M. documented at 4:00 A.M. the resident slid out of the recliner. Intervention included if the resident was awake in the middle of the night, especially during rounds, staff transferred the resident to the wheelchair so he/she could move himself/herself about. There was no evidence to support the facility reassessed the resident to determine the causal factors of the fall.

A nurse's note dated 11/14/14 and timed 8:15 P.M. documented the resident fell at 4:00 P.M. The resident partially stood up, leaned to his/her left and fell. The resident stated he/she did not

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need to use the bathroom, stated he/she was not going anywhere, he/she just wanted to see if he/she could stand. The note included the resident received a 1 centimeter (cm) skin tear at the base of his/her right thumb, a 1 cm scrape on his/her right middle finger, a 1 cm skin tear on hi/her left index finger, a 6 cm scrape on his/her left forehead, a 3 cm scrape on his/her left upper cheek bone and a 2 cm skin tear on his/her left upper cheekbone. The note included the facility would do a trial period with a Broda chair. The note included no interventions were implemented. There was no evidence to support the facility reassessed the resident to determine the causal factors of the fall.

On 11/13/14 at 7:47 A.M. the resident propelled his/her wheelchair from the dining room down the hallway.

On 11/13/14 at 12:00 P.M. direct care staff LL transferred the resident from the wheelchair to the toilet via the sit to stand lift. Direct care staff LL stated the resident did not need to toilet at 8:00 A.M. (after breakfast) and he/she toileted the resident between 9:30 A.M. and 10:00 A.M. Direct care staff LL stated staff toileted the resident every 2 hours or as requested.

On 11/17/14 at 7:10 A.M. the resident sat in a Broda chair in a reclined position. Observation revealed the resident had red colored abrasions on his/her left forehead and left cheek bone.

On 11/17/14 at 2:31 P.M. licensed nurse L stated the resident was at risk for falls. The resident fell out of his/her wheelchair on 11/14/14 and sustained the areas on his/her forehead and

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cheekbone. Licensed nurse staff L stated prior to Friday's fall the resident utilized a self-locking wheelchair and staff frequently toileted the resident. Licensed nurse L stated a week after the resident's admission the resident would not sleep in his/her room or his/her bed and since then slept in the recliner by the west nursing station. Licensed nurse L stated the resident fell and sustained a hip fracture since admission.

On 11/17/14 at administrative nursing staff D stated the resident was at risk for falls, staff frequently checked on the resident, the resident slept in a recliner by the nurse's station, and during the day sat in his/her wheelchair by the nurse's station, therefore the resident was usually within staff's eyesight. Administrative nursing staff D stated prior to the resident's fall on Friday the resident utilized a self-locking wheelchair. Administrative nursing staff D stated one of the resident's falls resulted in a hip fracture.
The facility failed to implement timely and effective interventions and also failed to reassess the resident for the causal factors of the falls for this resident with a history of falls and one of falls resulted in a hip fracture.

- Resident #1's quarterly Minimum Data Set (MDS) dated 10/20/14 included the resident scored
15 (cognition intact) on the Brief Interview for Mental Status, had no behaviors, required extensive staff assistance with bed mobility, transfers, dressing and personal hygiene. The MDS included the resident was totally dependent upon staff with toilet use, locomotion on/off the unit and the activity of walking on/off unit did not occur. The resident was not steady and was only able to stabilize with human assistance when moving from seated to standing position, moving

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on/off the toilet and surface to surface transfers. The resident had no functional limitation in range of motion, utilized a walker and wheelchair, was frequently incontinent of urine and was on a toileting program. The MDS identified the resident had 2 or more no injury falls since the prior assessment.

The resident's Activity of Daily Living (ADL) Care Area Assessment (CAA) dated 5/22/14 included the resident had a history of falls.

The resident's Fall CAA dated 5/22/14 included the resident had difficulty maintaining a standing position and had an impaired balance.

The resident's care plan last revised on 11/4/14 addressed the resident had an alteration in thought processes due to an intellectual disability (a disability characterized by significant limitations in both intellectual functioning and in adaptive behavior), had a self care deficit related to a muscular skeletal impairment, required staff assistance of 1 with transfers via the sit to stand lift and utilized (2) ½ rails at the head of his/her bed to promote bed mobility. The resident had difficulty with decision making, when staff reminded the resident of his/her safety issues the resident displayed anger and resisted assistance when needed. The resident had a potential for falls due to a decrease in muscle strength, and had a history of falls. Staff placed items including the resident's call light within the resident's reach, and frequently reminded the resident to stay in the Broda chair and to attempt to stand without staff assistance. An entry dated 8/14/14 included staff frequently reminded the resident to get close to things in his/her room and to not attempt to reach out and fall out of his/her Broda chair, staff kept the resident's closet door shut when not in

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use. An entry dated 9/21/14 included the resident utilized a Broda chair with foot pedals and staff ensured the Broda chair was lowered from the upright position after meals.

A fall and occurrence note dated 10/26/13 and timed 3:34 P.M. included at 2:39 P.M. the resident was in the central bathroom, had already used the bathroom, stood up and tried to bend down to pick up a paper towel he/she had dropped and lost his/her balance. The resident had an abrasion on his/her right knee that measured 1.0 centimeters (cm) in diameter. Interventions included the resident would no longer use that bathroom, was told of the interventions but the resident may not follow the interventions. Staff notified the activities and kitchen departments as staff sometimes wheeled the resident to the central bathroom upon the resident's request.

A fall and occurrence note dated 12/5/13 and timed 5:55 A.M. documented on 12/4/13 at approximately 6:30 P.M. the resident reported to the off going charge nurse that he/she fell and the resident complained on left shoulder pain. Interventions included a possible high rise toilet, toilet support grab bars and non skid strips on the floor. The resident stated he/she had to use the toilet, was in a standing position in his/her bathroom facing toward his/her room, was just standing, fell and hit his/her shoulder on the toilet.

A fall and occurrence note dated 1/24/14 and timed 10:06 A.M. documented at 9:16 A.M. staff observed the resident on the floor in his/her bathroom. The resident stated he/she was getting off of the toilet, lost his/her balance and fell. Staff suggested the resident allowed staff to assist him/her with toilet use and the resident

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became upset with the idea. The resident at the time of the fall was using the toilet in his/her room and not in the public restroom which was an issue in the past. The clinical record lacked evidence the facility did a roo cause analysis to determine the cause fo the fall.

A fall and occurrence note dated 5/2/14 and timed 5:14 P.M. documented staff observed the resident on the floor in his/her room. The resident stated he/she stood up to shut his/her door, lost his/her balance and landed on his/her bottom. Interventions included staff reminded the resident that he/she required staff assistance due to numbness in his/her right leg. The clinical record lacked evidence the facility did a roo cause analysis to determine the cause fo the fall.

A fall and occurrence note dated 5/13/14 and timed 3:15 P.M. documented staff observed the resident on the floor in the central bathroom. The resident stated he/she stood up to spit in the sink, lost his/her balance and fell. Interventions included staff provided the resident a cup for the resident to spit in and reminded the resident he/she was not to stand without staff assistance. The clinical record lacked evidence the facility did a roo cause analysis to determine the cause fo the fall.

A fall and occurrence note dated 5/16/14 and timed 1:06 A.M. documented at 10:15 P.M. staff observed the resident on the floor in his/her room. Direct care staff asked the resident to wait for him/ her to assist him/her to get dressed for bed. The direct care staff went to finish his/her

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previous duties and upon his/her return found the resident on his/her knees in front of his/her bed and the resident had an abrasion on his/her right knee. Dycem was in the resident's wheelchair and when staff assisted the resident back into his/her wheelchair the resident reached for something and almost fell out of the wheelchair. Interventions included staff consulted with physical therapy about a Broda chair, staff reminded the resident constantly to ask for staff assistance and to not bend down and reach for things on the floor. The resident had several falls, had recently slid from the wheelchair and refused help from staff. The resident now utilized a Broda chair and dycem was placed in the chair to help keep the resident from sliding.

A fall and occurrence note dated 8/1/14 and timed 5:08 A.M. documented on 7/31/14 at 5:30 P.M. staff observed the resident on the floor. The resident attempted to stand up on his/her own. Interventions included staff encouraged the resident to not attempt to get up by himself/herself and the resident's call light was not within reach. The facility educated direct care to not leave the resident alone in his/her room without a call light within reach because the resident was unable to move his/her chair freely around the room. The facility educated staff when the resident sat on the edge of the chair, do not just tell the resident to slide back but to also ask the resident if he/she needed anything to prevent the resident from having a reason to get up by himself/herself. The facility encouraged staff to propel the resident down to the dining room before staff assisted other residents.

A fall and occurrence note dated 8/13/14 and

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timed 5:29 A.M. documented on 8/12/14 at 10:45 P.M. staff observed the resident on the floor in his/her room. The resident attempted to stand without staff assistance and without an assistive device. Interventions included the facility educated staff on the need to keep the resident's closet door shut and to ensure the resident's room was picked up and neat andstaff encouraged the resident to utilize the call light.
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A fall note dated 9/19/14 and timed 12:26 A.M. documented on 9/18/14 at 8:00 P.M. staff observed the resident was on the floor in his/her room. The resident stated he/she slid out of the Broda chair and staff reminded the resident to not lean forward in his/her chair because the resident easily lost his/her balance and reminded the resident to ask for assistance when necessary. The Broda chair was not in a low position and the resident sat upright and the facility educated staff that the Broda chair must be returned to a low position after meals and activities.

On 11/13/14 at 8:15 A.M. the resident sat in the Broda chair at a dining room table.

On 11/13/14 at 4:50 P.M. the resident sat in the Broda chair and staff propelled the resident up the hallway. Observation revealed the Broda chair had foot pedals in place and the Broda chair was in a reclined position.

On 11/17/14 at 7:20 A.M. the resident sat in the Broda chair in his/her room. Observation revealed no foot pedals in place, the resident sat

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forward in the chair, and attempted to propel the chair with difficulty. The resident stated he/she utilized the Broda chair because he/she had fallen and could not walk. The resident also stated he/she could not maneuver the Broda chair.

On 11/17/14 at 11:40 A.M. the resident sat in the Broda chair and staff propelled the resident. Observation revealed no foot pedals in place and the Broda chair was in a reclined position.

On 11/17/14 at 2:25 P.M. licensed staff L stated the resident was at risk for falls and utilized a Broda chair to minimize falls. Licensed nurse L stated staff reminded the resident to ask for staff assistance and to reach for things on the floor and staff ensured the resident's closet door was closed and ensured the resident's bed was in a low position.

On 11/17/14 at 3:43 P.M. administrative nursing staff D stated the resident was at risk for falls, staff ensured the resident's bed was in a low position and utilized a Broda chair for positioning to prevent falls.

On 11/17/14 at 11:44 A.M. direct care staff T stated the resident was at risk for falls and staff toileted the resident before and after meals. Direct care staff T stated the resident utilized a Broda chair and a low bed to minimize falls and staff reminded the resident to ask for staff assistance for transfers.

The facility failed to do a root cause analysis and

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failed to place timely and effective fall interventions in place for this resident with an intellectual disability and a history of falls.

- On 11/10/14 from 2:35 P.M. to 3:16 P.M. water temperatures were taken on all halls of the facility. The temperature of the water temperatures were as follows: Observation revealed the water temperature in 3 rooms on the SouthWest hallway were 127.9 degress Fahrenheit (F), 128.1 degrees F, 127.7 degrees F.

Two resident's rooms water temperature on the NorthWest Hallway measured 127.9 degrees F and 117.5 degrees F.

Seven resident's rooms water temperature on the NorthEast Hall measured 126.5 degrees F, 123.9 degrees F, 125.9 degrees F, and 124.8 degrees F, 126.1 degrees F, 126.8 degrees F, 126.5 degrees F and 127.4 degrees F.

A resident's room on the SouthEast hall water temperature measured 126.6 degrees F.

During interview with maintenance staff X on 11/13/14 at 3:15 P.M. the staff stated he/she adjusted the temperature of the water heater which increased the temperature of the water. Maintenance staff X accommpained the surveyors to 2 of the resident's rooms and confirmed the water measured at 127.9 and 128.1 degrees F.

Review of the facility water temperature logs from 8/14 to 11/9/14 revealed the facility measured the water temperatue in 4 residents rooms on a weekly basis (different rooms). Further review

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F 323	Continued From page 73 revealed the temperatures ranged from 108 degrees F to 116 degrees F. The facility's undated Water Temperature Monitoring Policy and Procedure included the facility maintained a hot water distribution system with temperatures that are safe for residents and staff in the normal range of 98 degrees F to 120 degrees F. The facility failed to ensure water temperatures in resident's rooms were maintained at a safe level. - On 11/10/14 during Stage 1 of the survey observation revealed a melon sized hole in the bathroom floor with a pipe in the center of the hole. Further observation revealed the hole covered with a moveable trash can. Observation revealed resident #70 who resided in the room ambulated independently and was identified as having moderately impaired cognition. Observation also revealed several residents with wandering tendencies on the west hall. During interview with administrative staff A on 11/10/14 at 4:15 P.M. he/she stated the room had a water leak in the shower area of the resident's room. The facility failed to ensure the resident's room was as free from accident hazards as possible.	F 323		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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This Requirement is not met as evidenced by:
The facility reported a census of 86 residents. The facility had one main kitchen that served 2 dining rooms. Based on observation and interview, the facility dietary staff failed to serve food in a sanitary manner for 2 of 2 dining rooms on 1 of 4 four days onsite of the survey.

Findings included:

- Observation on 11/13/14 at 11:22 A.M. dietary staff DD and EE served lunch, from the kitchen and from a steam table in the assisted dining room. Dietary staff DD wore gloves while preparing the residents meal plates. He/she touched paper and dietary cards handed to him/her by a Certified nurse aide (CNA), touched his/her body with open hands, laid hands on the serving table, picked up a pie tray from a bottom shelf of a cart and placed it onto another table, then continued to use serving utensils and the contaminated gloved hand to place biscuits onto plates for the residents. Dietary Staff DD changed his/her gloves at 11:30 A.M. after opening an oven. He/she did not wash his/her hands and applied clean gloves. At 11:32 A.M. dietary staff DD wiped his/her hands down the sides of his/her apron, touched a dietary card handed to him/her by a CNA, and touched the biscuits with the contaminated gloved hand. Tongs were not used to handle the biscuits.

The Serving Food Safety sheet located on the bulletin board in the kitchen revealed the proper

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F 371	Continued From page 75 way to handle bread included the use of tongs and hands were not appropriate to use for handling breads. Staff interview on 3/13/14 with dietary staff EE stated changing gloves and handwashing should be done every time staff changed jobs or worked with different foods. He/she stated staff should wash their hands after touching body parts. If staff wore gloves then tongs were not used for dining service. The dietary cards were sanitized prior to each meal but after staff touched them they were no longer sanitized. There was a potential for cross contamination. Staff interview on 11/13/14 at 12:42 P.M. with dietary staff DD stated when staff don't wear gloves they washed their hands all of the time. When going from a food to a different food he/she did not touch the food. The biscuits were easier to handle without the use of tongs. Staff interview on 11/17/14 at 2:39 P.M. with administrative nursing staff D stated he/she did not want there to be cross contamination. If a glove was contaminated by touching a body part or another object then it was considered contaminated. He/she saw dietary staff handling biscuits using gloved hands and as long as the glove remained clean it was fine. The Dietetic Services policy, not dated, provided by the facility recorded all food would be be procured, stored, prepared, distributed and served under sanitary conditions. The facility failed to serve food in a sanitary manner for one of four days onsite of survey.	F 371		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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F 441	Continued From page 76 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This Requirement is not met as evidenced by: The facility identified a census of 86 residents.	F 441		

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F 441	Continued From page 77 Based on observation, record review, and staff interview, the facility failed to clean a residents room that minimized the transmission of infection for 1 of 3 days on site of the survey. Findings included: - Observation on 11/12/14 at 1:16 P.M. housekeeping staff Z wore gloves when he/she came out of one resident's room after cleaning, and entered another resident's room with the same gloves and started cleaning the restroom. On 11/12/14 at 1:18 P.M. housekeeping staff Z sprayed Meyer LD 64 (a chemical used as a disinfectant) into the sink and immediately wiped the sink with a washcloth. He/she then used this washcloth and wiped the toilet, grab bars, and shelves in the bathroom. Housekeeping facility staff did not spray the toilet, grab bars by the toilet or shelves in the bathroom. At 1:22 P.M. the sink and toilet were dry. At 1:24 P.M. the housekeeping staff Z mopped the floor with Meyer LD 64, and was dry at 1:32 P.M. He/she wore the same gloves, wiped the blinds, dressers and moved a resident's wheelchair. He/she failed to wipe door knobs or light switches. Review of the manufacturers instructions on 11/12/14 at approximately 1:30 P.M. revealed Meyer LD 64 must remain wet for ten minutes. On 11/12/14 at approximately 1:25 P.M. housekeeping staff Z stated the Meyer LD 64 disinfectant works very quickly and only needed to stay wet for a few minutes.	F 441		

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F 441	Continued From page 78 On 11/12/14 at 1:33 P.M. housekeeping supervisor Y stated the Meyer LD 64 disinfectant needed to stay wet for ten minutes, and he/she expected the housekeeping staff to spray the furniture directly and wipe the product off after ten minutes or let air dry. He/she expected housekeeping staff to change gloves often especially after the toilet, and staff were expected to wiped down door handles and light switches daily. The undated policy and procedure for housekeeping revealed staff used a clean rag dipped in the LD 64 solution to clean above floor surfaces to include light switches and door knobs. The facility failed to follow manufacturer's instructions to cleaning a room to minimize the transmission of infection, failed to clean all areas of the residents room, failed to change gloves between resident rooms, and during a room clean.	F 441		